STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 86390-001**

v

Health Alliance Plan of Michigan
Respondent
_____/

Issued and entered
This 28th day of December 2007
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On November 20, 2007, XXXXX (Petitioner) filed a request for external review with the Commissioner of the Office of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On November 27, 2007, after a preliminary review of the material submitted, the Commissioner accepted the request.

The issue in this matter can be resolved by applying the terms of coverage as defined in the Health Alliance Plan subscriber contract (the contract). It is not necessary to get a medical opinion from an independent review organization. The Commissioner reviews contractual issues under MCL 500.1911(7).

II
FACTUAL BACKGROUND

The Petitioner is a member of Health Alliance Plan (HAP), a health maintenance organization. On April 19, 2007, XXXXX, MD, performed a mini parathyroidectomy at XXXXX in

XXXXX, XXXXX. Dr. XXXXX and XXXXX are outside HAP's service area and are not affiliated providers with HAP. As of the date she filed her request for external review, the Petitioner said she had paid $9,375.00 for these services.

The Petitioner requested retroactive coverage for the surgery. HAP denied the request and the Petitioner appealed. After the Petitioner exhausted HAP's internal grievance process, HAP maintained its denial and sent the Petitioner its final adverse determination letter dated November 9, 2007.

III
ISSUE

Did HAP properly deny the Petitioner's request for coverage of services from a non-affiliated provider under the terms of its contract?

IV
ANALYSIS

PETITIONER'S ARGUMENT

The Petitioner says that the reason she decided to have the mini parathyroid surgery with Dr. XXXXX instead of XXXXX Hospital was because it was less invasive, less risky, and could be done on an outpatient basis. She says that after parathyroid surgery was recommended by her doctor in the XXXXX (her assigned physician group), she was told that there would be a 6" to 8" incision and that she would be in the hospital for one to three nights.

The Petitioner researched parathyroid surgery on the internet and learned that Dr. XXXXX's mini procedure is done with a 1" to 1½" incision and the surgery lasts only 16 minutes followed by one or two hours in the recovery room. She says that Dr. XXXXX does 12 of these surgeries each day, over 1,800 a year.

In contrast to Dr. XXXXX, the Petitioner says the XXXXX Hospital website shows at least a 4" incision for parathyroid surgery, does not say how many parathyroid surgeries they have done or their success rate, does not mention how long of a hospital stay is required, and does

not indicate if XXXXX Hospital offers both a standard and a mini parathyroidectomy.

The Petitioner argues that given the circumstances (i.e., HAP's failure to respond timely in treating her condition, her belief that HAP's physicians "failed to advise, support and give professional guidance," and the lack of information about whether XXXXX Hospital even performs the mini parathyroidectomy), it was necessary to have the service performed from a non-affiliated provider.

The Petitioner believes HAP should cover the parathyroidectomy by Dr. XXXXX at XXXXX Hospital.

HAP'S ARGUMENT

In the final adverse determination letter dated November 9, 2007, HAP's grievance committee denied coverage for the surgery:

> You are requesting HAP to authorize and reimburse you for the parathyroidectomy surgery you received from Dr. XXXXX in XXXXX, XXXXX. It was noted that prior to your services with Dr. XXXXX, you did not seek a second opinion from a XXXXX or HAP affiliated surgeon. However, after careful consideration of your presentation and medical records, a decision was made to uphold the denial because the same type and level of parathyroidectomy surgery is available within the XXXXX.

HAP says that the Petitioner received the surgery without prior authorization and that care from a non-affiliated provider without prior approval is specifically excluded under the contract. HAP believes it denial was appropriate.

COMMISSIONER'S REVIEW

HAP's contract explicitly excludes coverage for services rendered by a non-affiliated provider without approval from HAP. The contract says:

> **SECTION 5 – EXCLUSIONS AND LIMITATIONS**
> **The following are not covered under this Contract:**
> *** * ***

5.2 Other Exclusions

(a) Services provided by a non-Affiliated Provider, except for an Emergency or Urgent Care or when specifically approved in advance by HAP or its designee. [Emphasis added]

The contract also places certain responsibilities on the Petitioner:

6.2 Responsibilities

*** * ***

(j) You have a responsibility at the time of enrollment to select a single Physician Network or medical group and a single PCP [personal care physician] for your medical care. For selected Physician Networks or Medical Group, most Covered Services require a referral from your PCP, and most referrals from your PCP will be to Affiliated providers within your chosen Physician Network or Medical Group.

(k) You have a responsibility to satisfy all referral, authorization and assigned network requirements described in this Contract, regardless of whether HAP pays as the primary insurer or otherwise.

The contract also says (page 1):

> Because Health Alliance Plan is an HMO, the services covered under this Contract must be provided, arranged or authorized in advance by your personal care physician (PCP). Your PCP is an Affiliated Provider that you choose who is primarily responsible for providing or arranging for health care services for you. In some cases, your PCP will also need to have services approved by us.

HAP did not approve in advance the surgery performed by Dr. XXXXX. Moreover, HAP says that the Petitioner contacted a HAP client services representative on April 9, 2007, 10 days before the surgery, and was told it would not be covered.

Nothing in the file contradicts HAP's assertion that there was no referral to Dr. XXXXX from the Petitioner's PCP, XXXXX, MD, and no prior approval was requested. Further, the Petitioner has not claimed that prior approval was not required because the services were for an emergency or for urgent care. HAP points out that Dr. XXXXX's care notes from March 20, 2007, say: "[The Petitioner] states that she is not willing to go with one of the XXXXX

endocrinologists at this point. She prefers to go to XXXXX, XXXXX, to an endocrinologist called Dr. XXXXX, and is willing to pay out of pocket if her care is not covered by her insurance."

The Petitioner says that she chose Dr. XXXXX because the surgery she needed or wanted was not available from an affiliated provider. However, even if that were true (and HAP denies that it is), the Petitioner must still follow the requirements of the contract and request prior approval for services from a non-affiliated provider.

The Commissioner finds that the Petitioner failed to satisfy all the referral, authorization, and assigned network requirements of the contract for services from a non-affiliated provider and therefore upholds HAP's final adverse determination.

V
ORDER

The Commissioner upholds HAP's November 9, 2007, final adverse determination in this matter denying coverage for the Petitioner's services from a non-affiliated provider. The denial was in accord with the terms and conditions of its subscriber contract.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

Ken Ross
Acting Commissioner